04352

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 202

1 PLACE OF DEATH

County Kent

Village or City Farm near Worton (No. ..... St.: ..... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Stillborn Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
M	W	

6 DATE OF BIRTH

4 (Month) 3 (Day) 1940 (Year)

7 AGE

Stillborn yrs. mos. ds. (If LESS than 1 day ..... hrs. or ..... min.?)

8 OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Farm. Worton Md

PARENTS:

10 NAME OF FATHER Bernard Baker

11 BIRTHPLACE OF FATHER (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emily Barly

13 BIRTHPLACE OF MOTHER (State or country) Kent Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) father

(Address) Worton Md

15 Filed Apr. 5. 1940. Alice C. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4 (Month) 3 (Day) 1940 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from ..... 192..... to ..... , 192 ,

that I last saw h..... alive on ..... , 192.....,

and that death occured on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Stillborn

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory —
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H P Copeland M. D.

4-3- 1940 (Address) Chestertown Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: on farm — DATE OF BURIAL: 7 - 4. 1940

20 UNDERTAKER: Self — ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1

N B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED MAY 6 1910

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04353

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Rock Hall
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Edesville
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Kent
City or town: Rock Hall Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Rural – Edesville
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: John T. Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col	Single

6 (b) Name of husband or wife: —
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 29 1913

8. AGE: Years: 27 Months: — Days: 24 If less than one day: hrs. min.

9. Birthplace: Rock Hall (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: —

FATHER
12. Name: Lewis Brown
13. Birthplace: Kent Co

MOTHER
14. Maiden name: Matilda Smallwood
15. Birthplace: Rock Hall

16. Informant: Father
Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 1940 (month) (day) (year)
Cemetery or crematory: Sharpstown Kent Co
Location: Near Rock Hall
18. Funeral director: Wm. H. Good
Address: Church Hill

19. April 29 1940 (Date rec'd by registrar) Mrs. T. B. Spurdens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1940, at 5-7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1939, to April 28 1940 and that I last saw h— alive on April 25 1940

Immediate cause of death	DURATION
Tuberculosis of Kidney	
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Johns Hopkins Hosp.
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: A. A. Bungard M.D.
M. D. or other
Address: Rock Hall Date signed 4/29/40

RECEIVED
JUN 3 1960
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04354

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Chestertown Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) 0
Stay in this community (yrs., or mos., or days) 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Kent
City or town Chestertown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Still Born Baby Cann

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 27, 1940

8. AGE: Years 0 Months 0 Days 0 If less than one day 0 hrs. min

9. Birthplace Chestertown Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

MOTHER
12. Name Georgie Cann
13. Birthplace Chestertown Md
14. Maiden name Lelia Brown
15. Birthplace Kent Co Md

16. Informant Olga Cann
Address Chestertown Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof Apr 27, 1940 (month) (day) (year)
Cemetery or crematory Chestertown
Location Father

18. Funeral director
Address

19. April 27 1940 (Date rec'd by registrar) Alice R Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 27 1940 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 19 to 19, that I last saw deceased on 19, and that death occurred at 5:55 P.M. Cause of death: Did not attend Deceased Expired Suddenly Med. Exam

DURATION

Due to Stillborn Premature Baby

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) no
Means of injury none Injured at work? no

23. SIGNATURE Dr Medical Examiner. M. D. or other
Address Chestertown Md Date signed Apr 27/40

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND

COPY OF CERTIFICATE OF DEATH

(NOTE—This is not a legal document)

STATE DEPARTMENT OF HEALTH
Bureau of Vital Statistics

Registration Dist. No.

1. PLACE OF DEATH:
County Kent
City or town Body found on Bay Shore
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
near Worton
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2.(a) IF VETERAN, NAME WAR

3.(a) FULL NAME Elozier C. Frances

3.(b) Social Security Number

4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

Original certificate filed in Jan. 1940

19. Informant
Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director
Address

19. (Data rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH on or about Jan 22 1940 19, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,
and that I last saw h alive on 19.

Immediate cause of death Body was found on Bay Shore on April 7, 40

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE
M. D. or other
Address Date signed

25. CERTIFIED AS CORRECT TO COUNTY REGISTRAR BY

Local Registrar

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87

CERTIFICATE OF DEATH

04355

Reg. Dist. No. 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Norton Md RFD. (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Kent
City or town Norton R F D Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Garrison

3. (b) Social Security Number ~~yes~~ None

4. Sex: M
5. Color or race: C
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Jasie Garrison
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Unknown
8. AGE: Years: 61 Months: Days: If less than one day ____ hrs. ____ min.
9. Birthplace: Colemans R F D Norton md (Town, county, and state)
10. Usual occupation: Farm work
11. Industry or business: Farm Work
FATHER 12. Name: John Garrison
13. Birthplace: Norton md
MOTHER 14. Maiden name: Sarah Garrison
15. Birthplace: maryland
16. Informant: Jasie Garrison
Address: 119 Norrison St Chester Pa.
17. Colemans (Burial, cremation, or removal. Which?) Date thereof April 24 1940 (month) (day) (year)
Cemetery or crematory: Colemans
Location: Colemans
18. Funeral director: B R Gallows
Address: Still Pond md.
19. April 24 1940 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19th 1940 at 3P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15th 1940 to April 19 1940, and that I last saw him alive on April 19th 1940

	DURATION
Immediate cause of death: Paralysis agitans	
Due to	
Due to	
Other conditions: Hardening Criteria	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. P. Unruh M. D. or other
Address: Still Pond Date signed 4/22/40

RECEIVED
MAY 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

04356

Reg. Dist. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Rock Hall R.D. 2 Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days) 0
Stay in this community (yrs., or mos., or days) 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Md County Kent
City or town Rock Hall R.D. 2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Adam Monroe Hopkins

3. (b) Social Security Number —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 17. 1940

8. AGE: Years ____ Months ____ Days 14 If less than one day ____ hrs. ____ min.

9. Birthplace Kent Co Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Lonnie E. Hopkins
13. Birthplace Kent Co Md

MOTHER
14. Maiden name Minnie Bias
15. Birthplace Kent Co Md

16. Informant Lonnie E. Hopkins
Address Rock Hall R.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 1940 (month) (day) (year)
Cemetery or crematory Shrewsbury
Location Near Rock Hall
18. Funeral director Lonnie Hopkins (father)
Address Rock Hall Md

19. May 1 1940 (Date rec'd by registrar) Mrs. J. B. Durding Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1940 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from April 19 to April 30 19 40 and that I last saw ____ alive on ____

Immediate cause of death Mal nutrition — DURATION

Due to Prematurity

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury none Injured at work?

23. SIGNATURE Dr. Geo. Hume R.D. 5 Dr. Peter medical Exam. Kent Co.
Address Chestertown Md M. D., or other
Date signed April 30/40

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04357

Reg. Dist. No. 200

1. PLACE OF DEATH:

County KENT

City or town GALENA

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Galena Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MARY Elizabeth Horsey

3. (b) Social Security Number NONE

4. Sex Female

5. Color or race white

6. (a) ~~Single, married~~, widowed, or ~~divorced~~ widowed

6 (b) Name of ~~husband or~~ wife Thomas Hopewell Horsey

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1855

8. AGE: Years 84 Months 2 Days 30 If less than one day hrs. min.

9. Birthplace Saint Louis Missouri (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Home

FATHER

12. Name Amit Rasin

13. Birthplace Kent Co Maryland

MOTHER

14. Maiden name Henrietta Kennard

15. Birthplace Kent Co. md.

16. Informant Hanson Horsey

Address Millington, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof apr. 8 1940 (month) (day) (year)

Cemetery or crematory Shrewsberry Cemetery

Location near Galena, md.

18. Funeral director Ralph H. Risilton Inc.

Address Chestertown, md by J. W.

19. April 6 1940 (Date rec'd by registrar) Ella Lee Jones Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1940, at 5:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1939, to April 4 1940, and that I last saw her alive on April 4, 1940.

Immediate cause of death Uremia — DURATION ?

Due to Dehydration & Vomiting — ?

Due to Bilateral direct hernia — ?

Other conditions Chronic myocarditis — ?

Cardiac hypertrophy — ?

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Emerson Houck, M.D. M. D. or other

Address Galena, Md. Date signed 4/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 04358

1. PLACE OF DEATH:

County Kent

City or town Massey
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Samuel Stephen Hurlock

3. (b) Social Security Number: 220-01-3160

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married, widowed, or divorced~~: Widower

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1879

8. AGE: Years 60 | Months 8 | Days 5 | If less than one day — hrs. — min.

9. Birthplace Massey, Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Carpenter

FATHER
12. Name Clarence Seamans Hurlock
13. Birthplace Kent County

MOTHER
14. Maiden name Adelaide McGinniss
15. Birthplace Kent County

16. Informant Mrs Mary Lucas Sister
Address Massey Md.

17. Burial (Burial, ~~cremation, or removal, Which?~~) Date thereof 4 (month) 18 (day) 40 (year)

Cemetery or ~~crematory~~ St Clements Cemetery

Location Massey Maryland

18. Funeral director Ralph H. Hilton Inc

Address Chestertown, Md

19. 4/16 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1940, at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1940, to Apr. 15th 1940, and that I last saw him alive on April 14th 1940.

Immediate cause of death Apoplexy

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 1 yr.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. L. Copeland M. D. or other

Address Millington Date signed Apr 15th 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

I

(T)

RECEIVED
JUN 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-a)

04359

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent

City or town Morgnee (Chestertown R.R.D.)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 58 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent

City or town Morgnee Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Chestertown R.F.D.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NW

3. (a) FULL NAME Helen Johnson

3. (b) Social Security Number None

4. Sex Female

5. Color or race Col

6. (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Henry Johnson

6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Apr 10 1881

8. AGE: Years 59 Months 0 Days 18 If less than one day ___ hrs. ___ min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual occupation home work

11. Industry or business home

FATHER
12. Name Isac Cotton
13. Birthplace Maryland.

MOTHER
14. Maiden name Nancy T. Wilson
15. Birthplace Maryland.

16. Informant Mr Henry Johnson
Address Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30, 1940 (month) (day) (year)

Cemetery or crematory Morgnee

Location Morgnee Kent Co Md.

18. Funeral director Marvin V. Williams
Address Chestertown Maryland.

19. Apr. 30. 1940 (Date rec'd by registrar) Alice K. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1940, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15 1940, to 4-28 1940 and that I last saw her alive on 4-28-40 19

Immediate cause of death Pyelitis ~~[illegible]~~

DURATION unknown

Due to

Due to

Other conditions Bronchopneumonia - terminal
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert W. Farr M. D. ~~or other~~

Address Chestertown, Md. Date signed 4-30-40

RECEIVED
MAY 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1316)

04360

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Front Str.

Stay in hospital or inst. (yrs., or mos., or days): no

Stay in this community (yrs., or mos., or days): life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Kent

City or town: Chestertown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Front
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Isabell Johnson

3. (b) Social Security Number:

4. Sex: F

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: James Johnson

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1896

8. AGE: Years 44 ~~1896~~ Months ~~Feb~~ 2 Days 5 If less than one day ____ hrs. ____ min.

9. Birthplace: Chestertown, Md
(Town, county, and state)

10. Usual occupation: Domestic service

11. Industry or business

FATHER
12. Name: George Brown
13. Birthplace: unknown

MOTHER
14. Maiden name: Anna Bell Yorker
15. Birthplace: Chestertown Md

16. Informant: Annabell Yorker

Address: Chestertown

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: April 18, 1940
(month) (day) (year)

Cemetery or crematory: James M. E. Cemetery

Location: Chestertown

18. Funeral director: W. H. Good

Address: Church Hill Md

19. April 18, 1940 (Date rec'd by registrar) Alice R. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1940, to Apr. 16 1940, and that I last saw her alive on Apr. 13 1940.

Immediate cause of death: Chronic nephritis and valvular heart disease

Due to: Streptococcus infection

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no others

Of autopsy:

DURATION: 6 months

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Dr. Wm. Richmond
M. D. or other

Address: Chestertown Date signed: 4/16/40

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04361

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent

City or town Chestertown R D

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) all life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Kent

City or town Chestertown R D Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lucinda Johnson

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Tom Johnson

6(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1868

8. AGE: Years 72 Months 2 Days 3 If less than one day hrs. min.

9. Birthplace Kent Co Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Perry Hamilton

13. Birthplace Kent Co Md

MOTHER 14. Maiden name Jane Hackett

15. Birthplace Kent Co Md

18. Informant Deborah Lewis

Address Chestertown R D Md

17. burial (Burial, cremation, or removal, Which?) Date thereof Apr. 17, 1940 (month) (day) (year)

Cemetery or crematory Broad neck

Location Kent Co Md

18. Funeral director Asbury Henry

Address Chestertown Md

19. April 16, 1940 (Date rec'd by registrar) Alice R. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend he. Investigated case & signed certificate as deputy medical Exam. Kent Co and that I last saw him alive on 19 19

Immediate cause of death Grippe

Due to Lobar Pneumonia

Due to

Other conditions Asterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION 10 Days

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Hines M D Deputy Medical Exam. Kent Co M. D. or other

Address Chestertown Md Date signed Apr 15 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04362

Reg. Diat. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Kent

City or town: Rock Hall Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sarah Rebecca Middleton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem.	Wh.	Widowed.

6 (b) Name of husband or wife: James Middleton

(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 20 1859

8. AGE:

Years	Months	Days	If less than one day
80	6	10	hrs. min.

9. Birthplace: Kent County, Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: James W. Middleton

13. Birthplace: Kent Co, Md

MOTHER — 14. Maiden name: L. Temperance Howard

15. Birthplace: Kent Co., Md

16. Informant: Miss Maude Middleton

Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal, which?) Date thereof May 3 1940 (month) (day) (year)

Cemetery or crematory: St. Paul's

Location: near Fairlee

18. Funeral director: Ralph H. Carlton Inc.

Address: Chestertown

19. May 2 1940 (Date rec'd by registrar) Wm. T. B. Dowding Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1940 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1940, to April 30 1940, and that I last saw h-r alive on April 30 1940.

Immediate cause of death: Cardiac decompensation — DURATION

Due to: Grippe, Bronchitis

Due to: Arteriosclerosis

Other conditions: Hypertension, Kidney disease

(Include pregnancy within 3 months of death)

Major findings: —

Of operations:

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: A. A. Burgard M. D. or other

Address: Rock Hall, Md Date signed 5/1/40

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04363

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Kent
City or town Near Massey
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 69 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Mt. Massey Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME John P. Moffett

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife (date) Ella A. Moffett
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) March 2, 1871
8. AGE: Years 69 Months 1 Days 9 If less than one day ____ hrs. ____ min.
9. Birthplace Kennedyville Kent County (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farm
MOTHER 12. Name Henry Moffett
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Elizabeth Grady
15. Birthplace Unknown
16. Informant C. Albert Moffett (Son)
Address Middletown Delaware
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13/40 (month) (day) (year)
Cemetery or crematory Galena, Kent Co. Md.
Location Galena, Kent Co. Md.
18. Funeral director Marvin V. Williams
Address Chestertown Maryland
19. April 13 1940 (Date rec'd by registrar) Ella Lee Jones Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1940, at 7-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1940, to April 11 1940, and that I last saw him alive on April 10 1940

	DURATION
Immediate cause of death: Chronic hypertension	3-20-40
arteriosclerosis	3-20-40
Due to	
Due to	
Other conditions: Cerebral Hemorrhage	4-7-40

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. R. Crumbley M. D. or other
Address Middletown Del Date signed 4-12-40

RECEIVED
MAY 8 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1314

CERTIFICATE OF DEATH

.04364

Reg. Dist. No. 700

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Kent

City or town Sassafras Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Sassafras Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George W. Pennick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Martha Pennick.

6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 20 - 1870

8. AGE: Years 69 | Months 11 | Days 22 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm work

FATHER 12. Name James Pennick

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Martha Pennick

Address Sassafras Md.

17. (Burial, cremation, or removal. Which?) Date thereof April 15-1940 (month) (day) (year)

Cemetery or crematory Sassafras Md

Location

18. Funeral director W. H. Goode

Address Church Hill Md.

19. ____ 19____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1940, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1940, to April 12 1940, and that I last saw him alive on April 12 1940.

	DURATION
Immediate cause of death Acute Nephritis	
An acute attack engrafted upon a Chronic nephritis of unknown	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Wiles, M.D.
M. D. or other

Address Middletown Del. Date signed 4/13/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04365

Reg. Dist. No. 202

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: High St. Home

Stay in hospital or inst. (yrs., or mos., or days): None

Stay in this community (yrs., or mos., or days): 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: High St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Catherine Eloise Perkins

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: William E Perkins

Deceased — 6 (c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 17.1852

8. AGE: Years	Months	Days	If less than one day
87	9	17	____ hrs. ____ min.

9. Birthplace: Kent County Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

MOTHER FATHER

12. Name: James Lambert Davis

13. Birthplace: Kent County Md

MOTHER

14. Maiden name: Catherine Tilghman

15. Birthplace: Kent County Md

16. Informant: William Perkins Jr.

Address: 1324 W. Eleanor St., Phila. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6 1940 (month) (day) (year)

Cemetery or crematory: Mount Lebanon

Location: Ridge and Leighton Phila, Pa

18. Funeral director: Ralph H Hunton Inc.

Address: Chestertown, Md by J.W.Y

19. April 4 1940 (Date rec'd by registrar) Alice L Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3.1940 19____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan.16.1940 19____ April 3.1940 19____, and that I last saw her alive on April 3.1940 19____

Immediate cause of death: Pulmonary Oedema / ACUTE Myocarditis — DURATION: 6 days

Due to: Aterio Sclerosis / Paralysis — 5 yrs

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: Frank Innes M. D.

Address: Chestertown Md. Date signed: 4/3/40 4/3/40

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

04366

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 133 N. Queen St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 88 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 133 N. Queen St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Lewis L. Russell

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 19 1851

8. AGE:

Years	Months	Days	If less than one day
88	5	26	hrs. min.

9. Birthplace: Kent Co. Md.
(Town, county, and state)

10. Usual occupation: retired Clerk

11. Industry or business:

FATHER
12. Name: John Russell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth Greenwood
15. Birthplace: Unknown

16. Informant: Mr. L. Bates Russell Sr.

Address: Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/40 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown

18. Funeral director: Marion L. Williams

Address: Chestertown Maryland

19. April 16. 1940 (Date rec'd by registrar) Alice C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1940, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1939 to Apr. 14 1940, and that I last saw him alive on Apr 14 1940.

Immediate cause of death	DURATION
Arteriosclerosis	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. B. Simmons M. D. or other

Address: Chestertown Md. Date signed: Apr 15-1940

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

04367

Reg. Dist. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Rock Hall
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insl. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 21 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Kent
City or town Rock Hall Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mable Dorothy Sewell

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fe	W	married

6 (b) Name of husband or wife Frank M Sewell
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) April 11, 1898.

8. AGE: Years	Months	Days	If less than one day
42	11	25	hrs. min.

9. Birthplace Mayo, Anne Arundel, Md (Town, county, and state)
10. Usual occupation House wife
11. Industry or business
FATHER 12. Name Frederick C. Witt
13. Birthplace Germany
MOTHER 14. Maiden name Hannah Dahlman
15. Birthplace Germany
16. Informant Husband
Address Rock Hall, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8, 1940 (month) (day) (year)
Cemetery or crematory Wesley Chapel
Location Rock Hall, Md.
18. Funeral director Marvin Williams
Address Chestertown, Md.
19. April 8 1940 Mrs. T. B. Spurdine (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1940, at 12:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1940, to April 6 1940, and that I last saw her alive on April 6 1940.

	DURATION
Immediate cause of death Pneumonia	
Due to Carcinoma of liver (secondary)	
Due to Breast Carcinoma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. C. Flowers M.D. M. D. or other
Address Rock Hall Md Date signed 4/6/40

RECEIVED
MAY 2 1910
BUREAU V. S.